LSU

APPOINTMENT FORM

NAME: ____
Last First Middle Degree

SS#: ________________________ D.O.B. _______________ NPI#: _______________________

DEPARTMENT: __________________________ SUBSPECIALTY: _________________________

New Appointment: ______ Renewal: ______If Renewal, Did you Transfer from another Department? ______

Termination: _______ Transfer: _______From What Program: _______________________________

HAVE YOU EVER WORKED WITH ANY OTHER LSU ENTITY? __________ IF SO ID# ________

EFFECTIVE DATE: ______________________________

EXPECTED PROGRAM COMPLETION DATE: ______________________________

APPOINTMENT LEVEL: _______________________

BEEPER #: ____________________________ CELL#: _______________________________

EMAIL: ____

PROGRAM COORDINATOR: _____________________________ DATE: ____________________

PROGRAM DIRECTOR: ______________________________________

THIS FORM IS TO BE COMPLETED FOR ANY HOUSE OFFICER WHO WILL BE ON CLINICAL ROTATION AT UNIVERSITY MEDICAL CENTER NEW ORLEANS.

LSU

Graduate Medical Education

PERSONAL DATA FORM

PLEASE PRINT LEGIBLY OR TYPE

(Circle One): Internship Residency Fellowship

Department: ______________________________ House Officer Level:
(Level you will be in July) ____________

Name: ____
Last First Middle

Mailing Address: ____
Street City State Zip

Social Security Number: ______________ Citizenship: ____________________

Date of Birth: ________________ Place of Birth: ________________________

National Provider Identification (NPI#): ____________________

Beeper Number: Cell Number: Email: ______________________

Sex: Male_ Female _ Marital Status: S M W D Spouse's Name: ____________________

Race: (Please check one)
American Native ___Asian or Pacific Islander ___Hispanic ___White ___Black ____

List Person to Contact in case of Emergency: ________________________________

Relationship: ______________ Telephone Number: ________________________

PLEASE ATTACH THE FOLLOWING:

___ ACLS Certificate (If Applicable)

___ Copy of Medical License

___ Picture

Graduate Medical Education

House Officers/Fellows
Signature File

Name of Physician: ____
(Please Print)

ILH ID#: ____

School / Department: ____

Cell Number: __________________________ **Beeper Number:** _______________________

DEA License Number: ____

Signature of Physician: ____

UMC
UNIVERSITY MEDICAL CENTER
NEW ORLEANS

CODE GREY

SEVERE WEATHER PLAN

I hereby acknowledge receipt of the UMCNO Physician Disaster Plan for Code Grey and Code Grey Operations Plan. I understand that:

1. I am responsible for complying with the UMCNO Physician Disaster Plan for Code Grey and the Code grey Operations Plan.
2. I may be assigned to an on-call team by my Department Chairman/Section Chief/Chief Resident.
3. The UMCNO Chief Medical Officer has the final authority and responsibility for all assignments for all of the Staff (Medical Staff Members/Interns/Residents/Fellows).

____
Printed Name

______________________________ ______________________
Signature Date

Check appropriate status: □ Medical Staff Member x Intern/Resident/Fellow □ Advanced Practice Professional

Revised, 3/07, 6/07, 7/13

Medical Staff Services & Graduate Medical Education

Code of Conduct

ACKNOWLEDGMENT

This is to acknowledge that I have read and understand the University Medical Center New Orleans Medical Staff Code of Conduct.

____
(Print Name)

____
Signature   Date